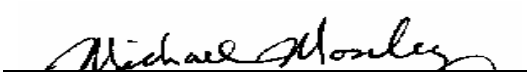
DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES
POLICIES AND PROCEDURES

Section:	Resource/Regulatory Management	**Effective Date:**	Upon signature
Team:	Accountability	**Policy No.**	ACC-1
Subject:	Provider Endorsement Appeal Policy	**Revision date :**	

Approved By:  **Approval Date:** 04/06/06

Purpose:

The process for obtaining corporate verification and provider endorsement are important safeguards designed to ensure that only qualified providers enroll with Medicaid to deliver mental health, developmental disabilities and substance abuse services. The endorsement application is used to determine and verify the eligibility of individuals or organizations to enroll in the Mental Health/Developmental Disabilities/Substance Abuse Services (MH/DD/SAS) system as providers and to ensure that individuals receive services from providers that are in compliance with service definition requirements according to the State Medicaid Plan. Providers are required to meet the provisions of relevant statutes, rules, regulations, and other program guidance including Centers for Medicare and Medicaid Services (CMS) rulings governing provider enrollment and service provision.

The purpose of this policy is to establish a method whereby providers may appeal the denial of endorsement by a Local Management Entity (LME) and LMEs who wish to provide an enhanced benefit service may appeal the denial of endorsement by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS).

Scope:

The endorsement process applies to providers wishing to enroll with Medicaid to provide MH/DD/SA services as a Community Intervention Services Provider. A provider who is denied endorsement by a LME or whose endorsement has been withdrawn as well as a LME which is denied endorsement or whose endorsement has been withdrawn by DMH/DD/SAS, has a right to appeal that determination as long as the appeal is filed according to the guidelines set forth in this policy.

Policy Statement:

This policy prescribes procedures and appeal steps by which prospective providers may appeal decisions made by the LME regarding corporate verification, provider endorsement and withdrawal of endorsement after having exhausted the reconsideration process at the LME

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level. It also prescribes procedures by which LMEs may appeal to the State DMH/DD/SAS Provider Endorsement Appeals Panel after being denied endorsement or when endorsement is withdrawn.

The review of endorsement applications for both providers and LMEs to provide MH/DD/SA services under the enhanced benefit package of the State Medicaid Plan shall result in one of three dispositions:

- Approval of application
- Return of application for additional information
- Denial of application

Grounds for Denial or Withdrawal of Provider Endorsement

A provider's endorsement application may be denied for the following reasons:

a) *Failure to Comply with Endorsement Requirements*: An endorsement application shall be denied when a provider fails to certify that it meets all applicable requirements of Medicaid policy and regulations, all federal and state licensure and certification requirements for the type service applied, that it has not employed or contracted with individuals or entities that have been excluded from participating in Medicaid or other federal programs.

b) *Relationships with Excluded/Debarred Individuals or Entities*: An endorsement application shall be denied if an owner, managing employee, authorized official, medical director, supervising physician or other individuals are excluded from Medicaid participation or other federal health care programs or debarred from federal procurement. A denial may be reversed if the provider submits documentation that the relationship with the excluded or debarred individual or entity has been terminated within 30 days of the notice of denial.

c) *Felony Convictions*: An endorsement application shall be denied when a provider entity or any of its owners have felony convictions determined to be detrimental to the best interests of the program. A denial may be reversed if the provider submits documentation that the relationship with the convicted individual has been terminated within 30 days of the notice of denial.

d) *False or Misleading Information*: An endorsement application shall be denied if it is determined that the information provided was false or misleading such that disclosing that information would have resulted in an endorsement denial. Information on the provider endorsement application must be certified by the applicant as true.

e) *On-site Review*: Endorsement may be denied if, on the basis of an on-site review, it is determined that the provider is not equipped to provide the services for which application for endorsement was made or the provider does not have available the professionals required to provide or supervise treatment.

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f) *Unlicensed Provider or Facility*: Endorsement may be denied if the applicant has not obtained the required state and local licenses, permits or authorizations (includes professional licenses and facility licenses) to perform the services it intends to provide.

g) *Not Operational to Provide Requested Service*: Endorsement may be denied if the applicant does not have a physical address where services can be provided, does not have a place where client records can be stored in accordance with HIPAA requirements or does not meet other requirements necessary to do business.

Withdrawal of provider endorsement may be initiated for the following reasons:

a) There is evidence of substantial failure on the Provider's part to comply with current rules, including 10 NCAC 26C .0502; or

b) The Provider has not satisfactorily addressed, within a reasonable time period, issues that endanger the health, safety or welfare of the individuals receiving services; or

c) The Provider has been convicted of a crime specified in G. S. 122C – 80; or

d) The Provider has not made available and accessible all sources of information necessary to complete the monitoring processes set out in G.S. 122-C -112.1; or

e) The Provider has not submitted the required documentation; or

f) The Provider has altered documents to avoid sanctions; or

g) The Provider has not submitted, revised or implemented a plan of correction within the specified timeframes; or

h) The Provider has not removed the cause of a summary suspension of DFS licensure within the specified time frame.

Enforcement: Division of MH/DD/SAS Resource/Regulatory Management Section will monitor the implementation of this policy. Failure to follow this policy shall result in loss of appeal rights to the DMH/DD/SAS Provider Appeals Panel.

Exceptions: None

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Procedure:

Responsibility:	**Action:**
Provider	A provider whose endorsement status is denied or withdrawn by a LME must first request a reconsideration of the decision by the LME prior to filing an appeal to the State. The request shall be made in writing to the Chief Executive Officer (CEO) of the LME within 15 business days from the receipt of the Notification of Endorsement Decision letter. The request shall contain a brief statement of the basis upon which the LME's decision is being challenged. The decision of the LME shall be considered final if a reconsideration request is not received by the Local Management Entity within 15 business days after the provider receives the Notification of Endorsement Decision letter or if the provider withdraws request for reconsideration. A provider is eligible to initiate an appeal to DMH/DD/SAS when: • Provider endorsement is denied after reconsideration by the LME. • The LME has utilized criteria to deny endorsement that are inconsistent with the DMH/DD/SAS provider endorsement policy. • The LME fails to complete the endorsement review process within the designated timeframes. • Provider endorsement is withdrawn and upheld by the LME during the reconsideration process. **Appeal Request:** If the provider does not accept the reconsideration decision, the provider may appeal in writing to the DMH/DD/SAS Accountability Team Provider Endorsement Appeal Panel within 15 business days from the receipt of the reconsideration decision from the LME. Endorsement application, notification of endorsement denial and supplemental documentation to support the provider's case shall be submitted with the appeal request. The provider has the burden of proof. An administrative review of submitted documentation will be completed by the Provider Endorsement Appeal Panel. **Informal Hearing Request:** If the provider does not accept the decision of the Provider Endorsement Appeal Panel after completion of the administrative review, the provider must make a written request for an informal hearing within 15 business days of the receipt of the administrative review decision. Both the provider and the LME involved in the provider endorsement review process will present at the informal hearing. The provider has the burden of proof. The provider may submit additional supplemental documentation to support the case with the written informal hearing request. Supplemental documentation will not be accepted on the date of the informal hearing.

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Office of Administrative Hearing Appeal Request: If the provider does not accept the informal hearing decision, the provider may submit a written appeal request to the Office of Administrative Hearings (OAH) within 60 business days of receipt of the DMH/DD/SAS informal hearing decision. Request for reconsideration, state appeal and OAH hearing shall be sent by certified mail.

LME

The LME shall respond to the provider's request for reconsideration of the endorsement denial or withdrawal of endorsement and make a reconsideration decision within 15 business days from the receipt of the provider's reconsideration request. The reconsideration decision made by the LME must be in writing. In the event provider endorsement is denied after reconsideration, the LME shall inform the provider of the right to appeal the decision and provide instructions on how to initiate an appeal and the timeframes within which the appeal shall be filed.
The LME shall attend and present at informal hearing requested by provider.

A LME whose endorsement status is denied or withdrawn must first request a reconsideration of the decision by the DMH/DD/SAS LME Team prior to filing an appeal to the State.

A LME is eligible to initiate an appeal to DMH/DD/SAS when:

- LME endorsement to provide Enhanced Benefit Services is denied by DMH/DD/SAS.
- DMH/DD/SAS has utilized criteria to deny LME endorsement that are inconsistent with the DMH/DD/SAS LME endorsement process.
- DMH/DD/SAS fails to complete the endorsement review process within the designated timeframes.
- LME endorsement is withdrawn and upheld by DMH/DD/SAS during the reconsideration process.

Appeal Request: In the event that a LME is denied endorsement, the LME may appeal in writing to DMH/DD/SAS Accountability Team Provider Endorsement Appeal Panel within 15 business days from the receipt of the denial letter from DMH/DD/SAS. Endorsement application, notification of endorsement denial and supplemental documentation to support the LME case shall be submitted with the written appeal request. The LME has the burden of proof. An administrative review of the submitted documentation will be completed by the Provider Endorsement Appeal Panel.

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Informal Hearing Request: If the LME does not accept the decision of the Provider Endorsement Appeal Panel after completion of the administrative review, the LME may request an informal hearing within 15 business days of the receipt of the administrative review decision. Both the LME and representative from DMH/DD/SAS involved in the LME endorsement review process will present at the informal hearing. The LME has the burden of proof. The LME may submit additional supplemental documentation to support the LME's case with the written informal hearing request. Supplemental documentation will not be accepted on the date of the informal hearing.

Office of Administrative Hearing Appeal Request: If the LME does not accept the informal hearing decision, the LME may submit a written appeal request to the Office of Administrative Hearings (OAH) within 60 business days of receipt of the DMH/DD/SAS informal hearing decision.

Denial of reconsideration, LME's request for appeal and informal hearing shall be sent by certified mail.

Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS) Responsibility

The Accountability Team will convene a three member appeal panel. The Provider Endorsement Appeal Panel shall consist of a member of the Accountability Team Policy Unit, a LME Liaison who is not the designated LME Liaison for the LME that denied provider endorsement or in the case of a LME which has been denied endorsement by DMH/DD/SAS, a LME Liaison who was not involved in the Endorsement Review of the LME, and another staff member from DMH/DD/SAS. The Accountability Team Policy Unit member shall serve as chairman of the Appeals Panel.

Administrative Review: Within 15 **business** days of the receipt of the initial written appeal request from a provider or an LME; the Provider Endorsement Appeal Panel will complete an administrative review to include a review of the endorsement application, reason for the denial and any supplemental documentation submitted by the provider or the LME. The decision of the appeal panel shall be by majority vote. The appeal panel will render a written decision and notify the provider and LME of its decision regarding provider endorsement or the LME and DMH/DD/SAS regarding LME endorsement within 15 business days of the administrative review.

Informal Hearing: The Provider Endorsement Appeal Panel will convene an informal hearing within 30 business days of the receipt of the written request for an informal hearing by the provider or an LME denied endorsement.

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The Provider Endorsement Appeal Panel will notify the provider and LME in the case of provider endorsement denial or the LME and DMH/DD/SAS in the case of LME endorsement denial of the date, time and location of the informal hearing at least 15 business days prior to the scheduled date of the hearing.

The Chairman of the Appeals Panel may afford the provider and LME the opportunity to present statements of the basis upon which the decision for denial is being challenged as well as discuss supplemental documentation submitted with the written informal hearing request. Additional documentation may not be presented on the day of the informal hearing. The Chairman of the Appeals Panel shall ensure that all persons present at the informal hearing address only the chairman or Members of the Appeals Panel. Direct exchanges between the provider, LME or DMH/DD/SAS shall be prohibited.

The panel will render a written decision within 15 business days after the informal hearing which may either affirm or modify its previous decision from the administrative review.

DMH/DD/SAS will inform the provider and LME of the right to appeal the informal hearing decision to OAH and provide instructions on how to initiate the appeal and the timeframes within which the appeal shall be filed.

Administrative Review decisions, Informal Hearing decisions and notification of hearing shall be sent by certified mail.

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